LOBBYOREGON

LEGISLATIVE UPDATE

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Coronavirus Impacts on Small Business

The House Economic Development Committee heard economists, chambers of commerce and business leaders talk about the impact of the coronavirus on Oregon's small businesses. The numbers are staggering.

- 72% decreased sales
- 44% decreased hours for workers
- 40% temporary business closure
- 35% Inability to pay other business expenses
- 27% laid off workers; 70% said they would have to layoff workers by July if conditions don't improve
- 20% inability to pay workers
- 2% permanently closed (3,000 companies)

(from a survey April 1-15 by Business Oregon)

The Chambers of Commerce asked businesses to describe the challenges they are facing and were told:

- Cash reserves are depleted
- PPE and sanitation products are limited
- COVID-19 lawsuits are coming
- Changing regulations make it difficult for businesses to reopen (eg., minimum wage scheduled to increase in July)

Economist Tim Duy said our economic recovery is intricately to the state's public health structure. But he said the prospects for many businesses are not good. "According to FEMA, 40% of businesses don't reopen after a disaster," he said. Of those that do reopen, 25% will fail within one year; and SBA estimates 90% of those that do reopen, fail within 2 years."

So Duy said, "We don't just have to restart our economy; we have to reimagine our economy."

Coronavirus Slows, Inequities Persist, and Looking Forward

Oregon has the 6th lowest coronavirus case rate in the US (93 cases per 100,000 people) and the 5th lowest death rate (4 per 100,000 people). Oregon has tested about 100,000 people, and last week saw a 2.6% positivity rate. "We're testing far more than enough people to be able to generally characterize the nature of the pandemic in Oregon," says Pat Allen, Director of the Oregon Health Authority (OHA)—"infections have reached a lull allowing us to begin reopening the state."

"We know there will be more coronavirus in the state. The idea is to keep that level at a rate that doesn't tax our health care systems, and is basically tolerable in terms of people's willingness to go about their day." Testing, tracing and isolating, as well as communication of data are key parts of their strategy.

Allen also told the House Health Committee that they have learned that “this crisis exacerbates and enhances the biases and inequities in our system,” and the initial crisis response did a poor job of acknowledging that. The OHA is committed to reducing those disparities moving forward and will focus much of its energy and spending on community-based organizations that have the deep and broad relationships to increase access to information and healthcare.

Over the next 30-90 days, the OHA will be preparing for a second wave of cases, finding ways to open schools in the fall, managing budget cuts and preparing for the long term. “We are in the middle of shifting from a short-term emergency response to realizing this will likely affect us for the next 12-24 months. We have to figure out a way to make this work sustainable within the agency and get back to some of the things we do normally” says Allen. Well-child visits and vaccination rates have plummeted in the last two months because people are unwilling to interact with the healthcare system or their provider is unable to see them.

Rep. Cedric Hayden (R-Cottage Grove) is concerned about the hundreds of thousands of people expected to switch from commercial insurance to Medicaid, and what it means for the state budget.

Pat Allen says it is a little too soon to tell. “We really need another quarter of data to be able to say anything numeric. But you’re right to be concerned.”

The Future of Telehealth

Prior to COVID-19, state law only required commercial health insurers to cover telehealth delivered via two-way video conferencing. Things have changed significantly since the beginning of the pandemic. Oregon has seen a 3000 percent increase in claims, and 4000 percent increase in claims paid compared with this time last year. Medicare has implemented pay parity for telehealth visits, as have CCOs and many commercial insurers. This has resulted in swift, broad adoption of telehealth services across care settings, and providers and patients are eager for those services (and the corresponding payment) to continue.

In March, Oregon’s Department of Consumer and Business Services (which houses the Insurance Division) and the Oregon Health Authority issued joint guidance on telehealth coverage for CCOs and commercial payers. Responding to concerns that many of the emergency policies issued by commercial insurers expire at the end of May, Insurance Commissioner Andrew Stolfi said, “That guidance will remain in place for the duration of the emergency.”

“We’ve been able to flip the switch and do telehealth in all kind of ways we weren’t able to before due to emergency waivers” says OHA Director Pat Allen. OHA is now working with Washington and California on a list of things they’ve done through those waivers that they will seek to make permanent.

Though coverage has certainly improved, commercial reimbursement remains inconsistent, as are the codes and modifiers used by those payers, says OMA lobbyist Courtni Dresser, which can result in delay or denial of claims.

OHA Director Pat Allen acknowledged those issues and noted that self-insured businesses are largely not participating.

Cambia’s Jim Polo noted that one of the policies that has significantly increased access—allowing non-HIPAA compliant video platforms for telehealth services—will change at some point, providing another potential barrier to continuing to provide these services.

Provider Issues

According to the OHA, 16% of COVID-19 cases in Oregon have been health care providers, 75% of which have been providing direct patient care. Meanwhile, personal protective equipment (PPE) is still a major issue, and supply chains are heavily inconsistent.

In a recent survey of members, the Oregon Medical Association found that only 33% of its members had adequate access to PPE. Emergency room physicians and the Oregon Nurses Association testified that frontline workers are being put in harm's way. Both called for greater transparency around how much PPE hospitals and the state have, and clearer standards for PPE protocol. And the Oregon Dental Association advocated that KN95 masks should be put back on the list of acceptable PPE, as many dentists purchased large supplies before the FDA removed them from the approved list. "The economic impact has been extreme for dental providers, as clinics have been closed for over two months. Costly PPE purchasing has exacerbated that. With limited revenue coming in, practices have been forced to furlough upwards of 50% of their staff" says ODA President Barry Taylor. Despite the Governor's ban on non-emergent procedures being lifted, many dental offices will be unable to resume care unless access to PPE is improved.

Provider issues extend far beyond PPE however. Most notable is the economic toll the pandemic has wrought on clinics and hospitals, as well as the potential for medical liability lawsuits. Providers can be held liable for delaying a patient's care, despite having limited options because of executive orders banning, or limiting non-COVID related care. They can also be held liable for medical malpractice if they deviate from what a reasonably prudent medical provider would have done, but those standards of care are hazy in a quickly changing response to a virus we know relatively little about. Providers deserve protection if they were following emergency orders issued by the state, says OMA's Courtni Dresser.

The ONA disagrees however, due to concern that liability protections would prevent frontline workers who contract the virus from accessing workers compensation. "We support presumptive causation for any essential worker contracting COVID-19 who files a workers' compensation claim" ONA Executive Director Sarah Laslett told the Committee.

The Economic Toll on Hospitals and Health Systems and Potential Paths Forward

Hospitals are hurting due to the economic fallout of the pandemic. Typical revenue streams dried up completely due to the ban on non-emergent care and patient reluctance to visit the hospital. "Federal relief has only covered about a third of losses thus far" says Hospital Association CEO Becky Hultberg.

In April, Providence saw ED visits down 40%, surgeries and procedures down 66%, and total gross revenue dropped 40%, says CFO Melissa Damm. "This cliff is like nothing we've ever seen in healthcare. It was swift and it was immediate." They saw significant decreases for admissions for serious health care events like heart attacks and strokes hearing from patients they were afraid of getting infected. The shift of many Oregonians to Medicaid, and the aging population, threaten their revenue model she says, as they rely on commercial reimbursement to cross-subsidize their funding.

From her perspective, it is critical that we change the way we pay for healthcare in order to stabilize the system. "If nothing else, COVID-19 has magnified our intense need to figure out a strategy supporting capitated payment models. This is critical culturally to allow practice models to change to lower cost settings, while reducing concerns of financial harm to providers.

We saw a 50% reduction of patient visits in March. Under a capitated payment model, the revenue stream remained constant for this population of primary care patients. Predictable income through capitation will help us weather another event like this better."

Health economist John McConnell provided the Committee with a few examples of payment models other states have implemented. As he put it, rural hospitals that have fewer admissions and smaller financial margins than urban models, are particularly vulnerable. Global budgets are a way of stabilizing their income streams.

Vermont, Maryland, Pennsylvania and Washington have all implemented new models to controls costs and better support for hospitals. CMS has provided $25 million to Pennsylvania hospitals for example to begin a 6-year demonstration in which hospitals will have at least 90% of their net revenue shifted to global budgets after year 2. The rationale is to move hospitals from a revenue center to a cost center, to provide incentives to use limited resources wisely, and to customize care and community support as needed.

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